Flexible Spending Account Administration Quote Questionnaire

Client Name: _____

Contact Name: _____

Address: _____

Phone Number: _____ **Email:** _____

Proposed Effective Date: _____

Is a plan currently in place? If yes, effective date of plan _____

Do you currently have a Cafeteria plan document in place? _____
Would you require a new one? _____

Number of Eligible FSA Participants: _____ **Number of FSA Enrolled Employees:** _____

Number of participants by plan:
Medical Spending _____ **Transportation** _____
Dependent Care _____ **Premium Accounts (if applicable)** _____

IS PAYROLL DATA CENTRALLY LOCATED: □Yes □No

CONDITIONS FOR ELIGIBILITY
Examples would be the same as the group medical plan, one year for medical spending and the same as the group medical for the premium only accounts, etc.

_____

_____

WILL THE EMPLOYER PROVIDE ANY CONTRIBUTION? □Yes □No

WHICH FLEXIBLE SPENDING ACCOUNTS WILL BE INCLUDED? (check all that apply)
□Medical □Dependent Care □Other Medical □Transportation

IS DEBIT CARD CURRENTLY BEING UTILIZED? □Yes □No
If yes, Which vendor do you use? _____

MEDICAL SPENDING ACCOUNT LIMIT: _____

CLAIMS PAYMENT SCHEDULE (check one)
□Weekly □Bi-weekly □Monthly □Semi-monthly

PAYROLL SCHEDULE (check one)
□Weekly □Bi-weekly □Monthly □Semi-monthly

REPORTING
Is reporting by location required? □Yes □No

840 Crescent Centre Drive, Suite 400
Franklin, TN 37067; 615-224-1600; 615-224-1624 fax

CAN ELIGIBILITY INFORMATION BE PROVIDED ELECTRONICALLY?

□Yes □No

IS CLIENT CURRENTLY UTILIZING ANY OF THE FOLLOWING: (Check all that apply)

□Web Enrollment □Website for Benefit Claim Information

□Debit Card Transactions □ Direct Deposit for FSA Funds

How did you hear about us? _____

Completed by: _____ **Title:** _____

Company: _____ **Date:** _____